

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF NUTRITION SERVICES AND WIC
WIC NUTRITION PROGRAM
VENDOR AUTHORIZATION APPLICATION

DATE RECEIVED BY STATE WIC OFFICE

OWNER/CORPORATION (OR Current Contract)

CURRENT VENDOR NUMBER

STORE NAME

STORE 'S STREET ADDRESS

P. O. BOX NUMBER

CITY

COUNTY

STATE

ZIP CODE

STORE TELEPHONE

STORE E-MAIL ADDRESS

STORE FAX NUMBER

STORE CONTACT PERSON FOR WIC PROGRAM

CONTACT PERSON'S TITLE

FEDERAL TAX ID NUMBER

FOOD STAMP AUTHORIZATION NUMBER

How long has this location been open under the current ownership? Years

Months

FACILITY AND OPERATION

Is the facility ADA (Americans with Disabilities Act) compliant? YES NO

If not, does the facility have an approved exemption status? YES NO (If yes, please attach a copy)

Store type: ____Grocery store ____Grocery store with pharmacy ____Pharmacy only ____Other

Square footage of the store:

Square footage allotted for food sales:

Hours of operation:

If open 24hours, 7days check here _____
If not, complete the schedule at right.
Do not include holiday shortened or extended times.
Dittos may be used when the times repeat.

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Total Annual store sales, all products: \$

Total Annual food sales: \$

Total Annual alcohol sales: \$

Total Annual tobacco sales: \$

Number of registers or scanners:

If scanners, do they differentiate WIC items?

SANITATION

A copy of the most recent sanitation report must be included with this application.

Has there ever been a closing due to sanitation at this location? YES NO

If yes, explain:

Are there unmet work orders or corrective action plans for sanitation violations? YES NO

If yes, explain:

SIGNATURE

TITLE

DATE

INSTRUCTIONS: An owner, officer, or manager must complete the following information in entirety and sign in appropriate areas to authenticate this document. *Failure to provide information as requested will be grounds for refusal to accept and process the application for authorization.*

Current Vendor Stamp (if applicable).

BUSINESS TYPE

Check the appropriate type from the list below:

_____ Sole Proprietorship	Privately Held Corporation _____ Yes _____ No	Missouri Based? Yes ____ no ____
_____ Partnership	Publicly Traded Corporation _____ Yes _____ No	Missouri Based? Yes ____ No ____
_____ MBE	_____ WBE	If Not Missouri Based List State _____

OWNERSHIP/CORPORATION IDENTIFICATION

OWNERSHIP/CORPORATION NAME		FEDERAL TAX I D NUMBER	
OWNERSHIP/CORPORATION MAILING ADDRESS		P.O. BOX NUMBER	
CITY		STATE	ZIP CODE
TELEPHONE NUMBER ()	FAX NUMBER ()	OWNERSHIP/CORPOARTION E-MAIL ADDRESS	

OWNERSHIP—LIST ALL CURRENT OWNERS. IF CORPORATION, LIST ALL OFFICERS (USE ADDITIONAL SHEET IF NECESSARY)

Please Print. NAME (LAST, FIRST, MIDDLE)	FULL ADDRESS	SOCIAL SECURITY NUMBER
CONFLICT OF INTEREST		

Are there any members of the ownership, management, or corporate officers who serve as board members or directors of an agency contracted with the Missouri Department of Health and Senior Services (DHSS)? YES NO

Are there any members of the ownership, management, or corporate officers who serve as board members, appointees or are elected officials with oversight of a public or private health agency? YES NO

Are there any members of the immediate family of the ownership, management, or corporate officers who serve as board members or directors of an agency contracted with the DHSS? YES NO

If yes to any of these three questions, please specify relationship and circumstance in detail. Attach additional sheets if needed.



HISTORY

1. List all stores owned by any of the owners or managers that are currently WIC vendors in Missouri or any other state. (Use additional pages if needed.) **Please Print**

OWNER NAME	STORE NAME AND ADDRESS

2. If any store has been acquired within the last three years, what is the relationship, if any, of the current owner(s) to the previous owner(s)? **Please Print**

STORE NAME AND LOCATION	DATE ACQUIRED	CURRENT OWNER NAME	PREVIOUS OWNER NAME	RELATIONSHIP

The Missouri WIC Program shall review the accuracy of all applicant qualifications and, shall make appropriate authorizations based upon the results of such review.

CERTIFICATION AND SIGNATURE OF OWNER, OFFICER OR MANAGER (Person who has the authority to apply on behalf of the business):

1. I apply for authorization as a vendor for the WIC Program, and I have authority to contract for the business.
2. I certify that during the last six (6) years that the vendor applicant or any of the vendor applicant's current owners, officers, or managers have not been indicted for, convicted of or had a civil judgment entered against them for any activity indicating a lack of business integrity. Activities indicating a lack of business integrity include fraud, antitrust violations, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, and obstruction of justice.
3. I consent to the release of necessary and required information on myself and/or this company/business to the Food and Nutrition Services administered by the United States Department of Agriculture; the Missouri Department of Health and Senior Services and its contractor's agents; and the Food Stamp Program, for the purpose of determining eligibility, program coordination, and conducting authorizations and compliance activities.
4. I certify that neither the vendor applicant nor any of the vendor applicant's current owners, officers, or managers have been disqualified, suspended, or have been assessed a civil money penalty from any USDA/FNS Program.
5. I hereby certify that the information presented in this application is true and factual to the best of my knowledge, information, and belief. I understand that misrepresentation of the information contained herein will nullify this application or will lead to contract termination if discovered later.

OWNER/REPRESENTATIVE SIGNATURE	DATE
OWNER/REPRESENTATIVE PRINT NAME	TITLE

The Missouri WIC Program is not obligated to contract with any retailer. Each applicant has the right to appeal the decision if the application is denied. Expiration of a contract is not subject to appeal.

This program is operated in accordance with the U.S. Department of Agriculture and the Missouri Department of Health and Senior Services policies which prohibit discrimination because of race, color, national origin, sex, age or disability.